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Sidonie Grunberg, et al.

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OUR MOST NEGLECTED MENTAL HEALTH PROBLEM: EMOTIONALLY DISTURBED CHILDREN

Keynote Speech to

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by

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Last year, the American Psychiatric Association and a number of organizations in the field of child psychiatry sponsored two conferences on planning mental health services for children in the new community mental health center program. As a prelude to their recommendations, they released what they regarded as the most reliable current data on the size and nature of the problem.

There is a seeming national consensus that there are about four million children under the age of fourteen who are in need of some kind of psychiatric intervention because of emotional difficulties. Of this number, anywhere from a half million to a million children are so seriously disturbed that they require immediate psychiatric help.

Very few of these children are getting the treatment which they need. Although close to 300,000 children were seen in outpatient psychiatric clinics in 1963, in most cases the "treatment" consisted of one or two diagnostic interviews followed by the admission that there were no facilities in the particular area for prolonged treatment.

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We have some rather sketchy data which indicate that about 14,000 of these children are confined in state mental institutions. We also know, on the basis of a trend which has been developing over the past five years, that by 1970 the number of children aged ten to fourteen hospitalized in these institutions will have doubled.

But those of us who visit a number of state hospitals each year are convinced that these estimates do not reflect the full extent of hospitalization for childhood mental illness. Furthermore, applications to the National Institute of Mental Health for Hospital Improvement Grants over and over again include detailed presentations which document the point that an amazingly high percentage of their long-term residents were first admitted as children or adolescents.

For example, an analysis of a 5,000 bed state hospital at Tuscaloosa, Alabama reveals that more than half of the male schizophrenic group who have been in that hospital twenty years or more were first admitted between the ages of fourteen and twenty-nine. The Alabama report estimates that one in every four young patients "can anticipate being permanently hospitalized for the next fifty years of their lives."

It is my contention that the increasing flood of these young children in the hospitals is not being reflected in existing national data.

If time permitted, I could cite a wearying array of material on the alarming rise in the number of children hospitalized in New York's massive mental institutions -- material gained in visits to these institutions over the past twenty years, and additional data gained over the last four years as a member of the National Mental Health Advisory Council reviewing hospital improvement applications from this state.

For example, the children's unit at Rockland State Hospital -- the second one in the country started in a state institution -- was once of manageable size and compassionate proportions. On my last visit to it -- approximately four years ago -- I was completely discouraged by the over-crowding and the lack of trained staff. Today, there are 700 children under the age of 16 at Rockland State -- ten percent of the entire hospital population -- and plans have already been completed for an additional 400-bed unit at that hospital to handle the rising tide of disturbed children being admitted annually. At Kings Park State Hospital out on Long Island, there are 360 children aged 5 to 15 residing in separate treatment units, and another 132 children between the ages of 16 and 18 who are jammed into adult wards because there is no program for them elsewhere. And so on, and on.

On innumerable previous appearances before legislative committees in New York State, I have inveighed against the building psychosis which seems to obsess all who have any responsibility for the running of the hospital system. More than a century ago, New York was alone among the states in violating the 200-bed ceiling for mental hospitals adopted by the Association of American Medical Superintendents, and you have been adding to your psychiatric real estate at a fantastic pace ever since.

In 1956, in a talk which I delivered in Syracuse to the first annual conference of the New York Community Mental Health Boards -- I haven't been invited back since -- I accused my native state of being "freighted down with an excess baggage of outmoded concepts concerning the time and place for psychiatric treatment. There is a really desperate need for flexibility and imaginative experimentation in the handling of children who are mentally ill. Sending an emotionally ill child off to a children's

unit in a state mental hospital, or even to a full-time private residential treatment center, is frequently the first step in the abandonment of that child. He is frequently cut off from the strength and warmth of his family, his community, and the children among whom he lives."

Two years later, after an 11-day tour of mental hospitals both upstate and downstate, I reported some of my findings to the annual convention of the League School for Seriously Disturbed Children here in this very hotel:

"Where are some of these troubled children?" I asked the audience. "Scores upon scores of them are in your state mental hospitals, crowded on wards with 80 to 100 very sick adults. To any of you who have any illusions about the type of 'treatment' given children in these Gothic institutions, I respectfully suggest that you talk to some of the children in these hospitals. I have, and it is a very bitter experience."

I cannot truthfully claim any success then in breaking through the walls of official and public apathy. The real estate boys up in Albany were busy spending Tom Dewey's final legacy -- a \$350 million bond issue passed in 1954 designed to add thousands and thousands of additional beds to the existing psychiatric real estate.

The situation is a little different today. You now have a Mental Hygiene Facilities Improvement Fund created by the 1963 legislature. This real estate agency has at its disposal \$500 million borrowed from the state housing fund at a considerable rate of interest. More than a year ago, the leadership in Albany announced that it intended to add an additional 30,000 beds to a system which already has more brick and mortar per 100,000 people than any state in the country -- twice as much, for example, as California, which refuses to build any more custodial beds. Under public pressure, there has been some modification of this building orgy, but the situation still bears careful watching.

This passion for building -- combined with severe shortages of psychiatric personnel -- has caused lifted eyebrows among many of the leaders of the psychiatric profession. As one of America's most renowned psychiatrists put it recently:

"They must have discovered a new therapy in New York State. The mental patient walks into a building and stands there. There is little or no staff because of personnel shortages. But the patient goes into the empty building every day for an hour and, after a few weeks, comes out cured."

But there is room for hope. Listen my children and you shall hear -- of the whirlwind tour of a man without fear. Even in the far country west of the mighty Hudson, we have heard of the forced march of Senator Kennedy through Willowbrook and Rome. Unseemly cracks are being exposed in the Victorian real estate and, if this trend accelerates, we citizens may have a real voice in deciding just when and where we want our loved ones treated.

I have a respectful suggestion for those of you interested in planning a constellation of children's services tailored to the individual needs of the child rather than to the mammoth appetite of the building contractors -- go to the "backward" state of Michigan which is located in the unsophisticated heartland of America and has less than half the population of the Empire State. I spent a day just a few weeks ago touring its facilities for children, and I came away increasingly bitter at the contrasting picture here in this state.

Hawthorn Center -- entirely state-supported -- was opened in 1956. It is 20 minutes from downtown Detroit on a wooded 25 acre spread. It handles approximately eighty children on an in-patient basis. They are housed in gaily furnished cottages -- the walls are decorated with fascinating paintings done by the children. There are

individual rooms for those who need them; the rest are housed in rooms containing either two or three beds. The top floor of each cottage boasts a massive living-recreation room dominated by a floor to ceiling stone fireplace. For the general use of the children, there is a big swimming pool, gymnasium, library, recreational patios, etc.

The day school -- presently housed in one of the cottages -- will soon move into a beautiful new building. It will be able to handle about one hundred children who will be transported daily to and from the school. It has the latest in teaching equipment, including a modern science building. Furthermore, the new school will initiate a pioneer program for children of nursery school age.

But the key to the entire Hawthorn program is personnel -- reams of professional and sub-professional people, and all of them able to converse in English. There are 13 full-time child psychiatrists, all of them certified or board-eligible. In addition, there are 12 psychiatric residents, plus countless social workers, psychologists, research associates, etc. There are 25 specially trained teachers or student-teachers of the emotionally disturbed -- Michigan was the first state in the nation to develop a special certification program for teachers of emotionally disturbed children.

It costs money to run this kind of a program -- about two million a year in state taxes. Expensive? Compared to New York's grandiose 500 million dollar building program, it's a drop in the bucket.

Hawthorn Center is not the solitary jewel in a shoddy crown -- it is merely one gem among many in the Michigan program.

The Lafayette Clinic in down-town Detroit-- entirely state-supported and one of the finest psychiatric facilities in the nation -- has a superb unit caring for 45 children.

It has a staff of eight full-time and seven part-time child psychiatrists. In the very near future, it will open two halfway houses especially designed to bridge the gap between residential treatment and return to school and home. At the University of Michigan, the Children's Psychiatric Hospital -- opened two decades ago -- has a unit caring for 54 children staffed by 12 full-time and three part-time psychiatrists.

In addition, Michigan is currently embarked on a program to build small residential units at each of its state hospitals with close ties to the surrounding communities through the use of additional day care centers at the hospitals. I talked to state mental health officials in Michigan, and they assured me of their determination to hold each of these units down to less than 100 children -- thus avoiding the dehumanization which has taken place here and in other states.

Over and above being a pioneer in University programs for the training of teachers of the emotionally disturbed, Michigan reimburses all school districts which establish special classes for these children.

In addition to the state mental hospitals across the country, there are a handful of residential treatment centers which care for about 2,500 children a year. In fifteen of our states there are no such facilities, either public or private; in twenty-four of our states, there are no public units to care for children from low and middle income groups.

To sum up, it is an undeniable fact that there is not a single community in this country which provides an acceptable standard of services for its mentally ill children running the spectrum from early therapeutic intervention to social restoration in the home, the school and in the community.

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Furthermore, practically no community in this country has reliable data on the number of emotionally impaired children. Deeply aware of this deficiency, the National Mental Health Advisory Council has awarded several grants recently to organizations competent to survey the extent of the problem. From my point of view, the key grant was awarded to Dr. Thomas Langner and his associates at the New York University Medical Center for a three-year sampling study in Manhattan of the extent of psychiatric impairment among urban children. The survey got under way last month, and we are confident it will turn up the statistical raw material which is a necessary prerequisite to intelligent planning.

As a nation, we now have a precious opportunity to create a new pattern of appropriate services for these disturbed children. Every state in the country is now engaged in completing plans for new community mental health services; it is incumbent upon all of us to insist that services for children be an integral and major segment of these new community mental health centers.

I have received the final version of the New York master plan -- all seven volumes of it -- and I cannot resist the observation that you again lead the rest of the country in compulsive gigantism.

However, I must admit in all fairness that the underlying thrust of the report is sound -- thanks to a revolt of the citizen planners, culminating in the battle of Saratoga Springs this past July, against another Albany-dictated "master" real estate plan. Essentially, the citizen plan proposes the creation of 150 community mental health centers covering all parts of the state by 1975. But again a word of caution: a shiny new center building will not cure one child, even by osmosis. The critical need is the

training of professional and non-professional workers in sufficient numbers to reach these children in a direct, meaningful way. I have grown weary of submitting master plans for training to the hierarchy in Albany. This is a job the reinvigorated New York State Association for Mental Health and the allied organizations represented at this historic Congress must tackle; if you do not, the whole new community center concept will be buried in architects' blueprints, bricks, mortar and the like.

I would like to underscore the hope that those of you who are designing these new services divest yourselves of any rigid notions as to what constitutes the "proper" facility for an emotionally disturbed child. Beyond an agreement with a position enunciated in a recent article in the "American Journal of Psychiatry" that hospitalization in most state mental institutions adversely affects the child because "he promptly loses the right to be a child", I would plead for a wide variety of services suited to the individual needs of each child and to the capabilities of each community.

There is a real danger, for instance, that we will overemphasize the need for residential treatment centers for children, thereby losing sight of the vast majority of disturbed children who do not need such 24-hour hospitalization. In this country, we tend to overemphasize hospitalization as the only way of handling a child who does not conform to the fierce and often conflicting demands of present day living. Psychiatric leaders in many other countries have been quite critical of our inability to handle these children in other ways than by total confinement. We do ourselves a great disservice when we push many of these mildly disturbed children out of the community and into a faceless institution.

You do it here in New York, and I have been an eyewitness to it. Five years ago, I rode a bus taking a group of children from the psychiatric wards at Bellevue -- where they had been mixed in with the sickest of adult psychotics -- to long-term confinement on the over-crowded wards at Rockland State, and I still shudder when I think of the heartlessness and callous extrusion involved in both the Bellevue and Rockland experiences.

Most of you here today are probably not familiar with "A Study of Children Referred for Residential Treatment in New York State", a report made in 1959 by the distinguished child psychiatrist Donald Bloch and his associates to the New York State Interdepartmental Health Resources Board. It is the most incisive description, in all the mountainous child psychiatric literature, of the almost hysterical American urge to shove the troubled child out of the community and into any kind of residential facility, however unseemly. Here is what the Bloch report had to say about what it castigated as "the inexorable trend toward the institutionalization of these children":

"Communities principally look to residential treatment for a solution to the problem of the child who needs placement. In this view of the matter, treatment is a secondary issue. In our study, although less than one-quarter of the children referred to residential treatment centers were admitted, well over 90 percent were ultimately placed in some kind of institution. For these children, the situation had passed a critical point. The forces pushing the child out of the community, the degree of illness, the deterioration of the family, the pathogenic factors in the environment, had overwhelmed the capacity of the community to keep the child living in it.

"Second, we were impressed throughout the study with the terrible cost levied by the lack of an over-all, unified, consistent plan for providing service to the seriously disturbed child. For the child with relatively minor difficulties, a single service may suffice to correct the problem. The children being considered here have all areas of their lives riddled with pathology and almost always need multiple services which are coordinated with each other. In general, services to these children are provided in discrete packages; agencies are over-specialized and separated from each other by a referral barrier that is often resistive and

sometimes impervious. School refers to court, court to clinic, clinic to placement agency, and so on. Once admitted to the hospital or treatment center, it is difficult or impossible to have the child accepted by an out-patient community agency. Integrated programs of service at the clinical level are literally unheard of."

Dr. Bloch has continued his studies in the handling of disturbed children in New York State, and I have been informed by project officers at the National Institute of Mental Health that his current findings serve to underscore, in greater depth, the original findings he transmitted to state officials six years ago.

We need a more flexible, less doctrinaire approach to the whole problem of the disturbed child. It isn't all just black or white -- successful adjustment or an institution several hundred miles away. It is in the intermediate areas where we can do the most effective job for the majority of these children -- in the schools, in the mental health clinics, the day care centers, the courts, and so on. By developing the screening and treatment potential of these familiar agencies, we don't run away from the problem -- we face it and we bring many untapped human resources to it.

I am particularly concerned with the enormous untapped potential of the schools in handling emotionally disturbed children. The Joint Commission on Mental Illness and Health, which was unable to devote sufficient attention to the problems of childhood mental illness because of a shortage of funds, did issue a monograph titled "The Role of the Schools in Mental Health". It is quite an important document, laying the greatest emphasis upon the therapeutic role of the schools because of their central position in the child's life. In the study itself, there are key sections devoted to skilled nursery education, the spotting of difficulties in kindergarten, the need for immediate intervention when basic learning difficulties become apparent.

To those of us who suggest these new approaches in settings other than rigidly psychiatric ones, there is the usual retort that we can never train enough psychiatric

manpower to do this kind of job. I agree. It is sheer folly to think that we can ever train enough personnel to give individual psychotherapy to every disturbed child. It would not only be inadvisable to do so in terms of available manpower, but I submit that it would be totally unwise.

As the Joint Commission report noted, we must add to the skills of those who deal most directly and continually with the child.

For the past four years, an experiment has been going on in Tennessee and North Carolina in which selected teachers are being taught psychiatric skills and then used as teacher-counsellors in specialized schools for disturbed children. This experiment follows the pattern of the French experience in which more than 3,000 of these teacher-counsellors play a key role in working with emotionally disturbed children in that country. Called Project Re-ED, the philosophy of its originator is stated very forcefully in a recent description of the first four years of the experiment:

"The problem of providing for emotionally disturbed children is a critical one requiring bold measures. Society will not continue to tolerate the assignment of disturbed children to detention homes, to hospitals for adults, or to institutions for the mentally deficient... The United States does not have and will not be able to train a sufficient number of social workers, psychiatrists, psychologists and nurses to staff residential psychiatric facilities for children along traditional lines. It will not be possible in the foreseeable future, with manpower shortages becoming increasingly more acute, to solve the problem of the emotionally disturbed child by adhering to limited patterns... For effective work with children, the worker's personal attributes weigh more heavily than his professional knowledge and technical skills. Re-ED represents an explicit break with the predominant philosophy of developing professional people in our society, a philosophy that minimizes individual differences and relies most heavily on extensive and expensive periods of training to assure competence."

While it is too early to make definitive comments on the success of these experiments, there is every indication that it is preventing the institutionalization of many children. The average stay of pupils at the specialized schools in Tennessee and North Carolina is about four months; the close and continuing liaison between the specialized schools and the regular school systems in the area provides a natural transition back to full-time schooling when it is deemed advisable.

In order to work more effectively with children in the schools, we need many more teachers specially trained to work with those who are emotionally disturbed. The U. S. Office of Education recently estimated that we need approximately 100,000 of these specialized teachers right now to staff classes of not more than ten children each for the more than one million children it estimates need these individual psychological and educational services. How many do we have now? The best estimate I could get out of the Office of Education was less than three thousand.

I am therefore delighted to report to you that the mental health center staffing legislation which passed the Congress this year also included a tremendous boost in programs for training teachers of the handicapped. Over the next four years, \$120 million is authorized for this purpose and, since the greatest need is for teachers of the emotionally disturbed as pointed out in the Senate report on the legislation, I am confident that for the first time in our history we will begin to close the gap between the supply and the insistent demand.

The aforementioned legislation also includes \$41 million over the next four years in support of research and demonstration projects designed to produce more effective methods of teaching and re-educating the handicapped, with a new proviso allowing federal support for the construction of such experimental facilities.

We can therefore look forward in the coming years to a number of new approaches as fruitful in originality as the George Peabody College experiment in Tennessee and North Carolina.

There are so many who could help. For example, as the Joint Commission report notes, there are 6,000 pediatricians in this country but the great majority of them lack sufficient psychiatric orientation to capitalize on their professional potential.

We have just begun to scratch this great potential of people who can help people. In Washington, D. C. we are using mothers whose own children have completed their education. They are given a year's training in psychiatric concepts and then work on the psychiatric service at Children's Hospital.

In many cities in the country, trained youth workers are going into neighborhoods where trouble exists and applying their knowledge and affection to those children who are in revolt against the "norms" of modern society. As the noted psychiatrist Dr. Kenneth Appel has pointed out, there is a deep and tragic irony in the fact that millions of Americans -- unemployed, retired, or otherwise rendered unproductive by society -- seek a meaningful role in life, while millions of our children, our mental patients and others sunk in despair seek a helping hand. Dr. Appel pleads for a linkage between this great untapped human potential and the vast needs of the troubled and submerged in our democracy. Automation may eventually provide most of the material wants of our society, but it cannot ever replace the hand-to-hand and heart-to-heart relationship which is at the core of the helping services.

During this past summer's experience with Project Head Start -- which reached more than 600,000 children under the age of six -- thousands of adults and children served as volunteers. As this program resumes this fall and winter, the goal is to reach down to children three years of age and to expand voluntary and community participation.

The first several thousand trainees of VISTA -- Volunteers in Service to America -- are now serving in all regions of the country. A sizeable percentage of these dedicated people have chosen to work in the mental health field and, having addressed several groups of VISTA trainees, I can assure you they will make wonderful workers in the vineyard of childhood mental illness.

There have been exciting developments in other areas of childhood mental illness which have highlighted the necessity for a comprehensive survey of existing needs and the selection of a set of priorities for the next decade and beyond.

The first incisive plea for such a national survey came in a resolution adopted by both the American Psychiatric Association and the American Academy of Child Psychiatry as a direct result of a 1963 conference on training needs in the field of child psychiatry. Noting that the survey of adult mental illness by the Joint Commission on Mental Illness and Health had led to a long-needed overview of the problem which resulted in positive recommendations and subsequent legislation, the conference adopted the following resolution:

"In sum, it was the consensus of the Conference that what the Joint Commission had done by way of presenting the nation with a program to combat mental illness as a whole should now be done in comparable manner and style for the problem of childhood mental illness. The Conference members recognized and accepted their obligation to inform the public of the needs of children and registered their opinion that a national survey should be conducted under the leadership of representatives of the entire spectrum of child-care professions in the field of mental illness and health. They pledged to work for the launching of such a study, looking to the formulation of a national program to combat childhood mental illness and to secure the wherewithal to carry out such a plan."

At the March, 1965 meeting of the National Mental Health Advisory Council, the membership of that Council voted unanimously to request the National Institute of Mental Health to explore with all national organizations interested in the emotional health of children the possibility of a joint commission survey comparable in depth and scope to the Joint Commission on Mental Illness and Health study.

I am happy to report that several exploratory meetings have been held, and that a Joint Commission on Mental Health Services for Children has been incorporated.

Legislation to provide one million dollars over a two-year period in federal support for this survey was passed in the present session of Congress, and it is hoped that the Commission can get going with its very vital work within the very near future.

The quest for a national blueprint of mental health services for children is of vital importance, but it is no substitute for continued efforts at the state and local level to meet the immediate and pressing emotional problems of so many of our children.

I am reminded of the statement made several decades ago by Katharine F. Lenroot, one of the great architects of the U. S. Children's Bureau:

"We are prodigal in our dreams for children, but often miserly in our deeds. And that, I suspect, traces back frequently to an elementary difficulty all of us have at times in knowing how to get from where we are to where we want to go."

We must now move boldly at the local, state and national level in identifying a broad set of objectives which will get us "from where we are to where we want to go."

I am confident that the Joint Commission on Mental Health Services for Children is the appropriate vehicle for this long delayed journey into the future, and I know that all of you here today will work with us in other parts of the country to see that it fulfills its terribly important mission.